

Attachment C—Year 1 Benefits
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Health Benefit Plans
Year 1 of the Waiver

Current State Plan Services	<u>Plan A</u> Pregnant Women 186 through 200% FPL 1619(b) Beneficiaries	<u>Plan B</u> Parents at or Below 50% of the Federal Poverty Level (FPL)	<u>Plan C</u> Parents 51% through 100% FPL (Premiums Based on Income may be Proposed in Future Years)	<u>Plan D</u> Childless Adults at or Below 35% FPL and County Health Plan Beneficiaries (Premiums Based on Income may be Proposed in Future Years)
Mandatory				
Inpatient Hospital	Covered	Covered	Benefit Limited to Payment of \$500 Per Diem for the first 5 Days of Inpatient Care	
Outpatient Hospital	Covered	Covered	Covered	Covered
RHC & FQHC	Covered	Covered		
Lab & X-ray	Covered	Covered	Covered	Covered
Nurse Practitioner	Covered	Covered (\$5 Copay for office visits)	Covered (\$10 Copay for office visits)	Covered (\$3 Copay at or below 35% FPL and \$5 copay above 35% FPL for office visits)
Nursing Facility & Home Health for Beneficiaries 21 and Older	Covered	Limited Home Health Benefit	Limited Home Health Benefit	
EPSDT for beneficiaries Under 21	Covered	Well Child, Preventive Services & Immunizations	Well Child, Preventive Services & Immunizations	(Children are not covered in this group since they would be eligible for Healthy Kids or MICHild.)
Family Planning	Covered	Covered	Covered	Covered

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Physician	Covered	Covered (\$5 Copay for office visits)	Covered (\$10 Copay for office visits)	Covered (\$3 Copay at or below 35% FPL and \$5 copay above 35% FPL for office visits)
Nurse Midwives	Covered	(Pregnant women are not covered in this group since the would be eligible under Healthy Kids.)	(Pregnant women are not covered in this group since the would be eligible under Healthy Kids.)	(Pregnant women are not covered in this group since the would be eligible under Healthy Kids.)
Maternity Services	Covered	(Pregnant women are not covered in this group since the would be eligible under Healthy Kids.)	(Pregnant women are not covered in this group since the would be eligible under Healthy Kids.)	(Pregnant women are not covered in this group since the would be eligible under Healthy Kids.)
Optional				
Ambulance	Covered	Covered	Covered	Covered
Podiatrist	Covered (Nominal Copay)			
Optometrist	Covered (Nominal Copay)			
Chiropractor	Covered (Nominal Copay)			
Other Practitioner	Covered			
Clinic	Covered	Covered (\$5 Copay for office visits)	Covered (\$10 Copay for office visits)	Covered (\$3 Copay at or below 35% FPL and \$5 copay above 35% FPL for office visits)
Dental	Covered (Nominal Copay)	Covered (\$5 copay for Class I)	Covered (\$10 copay for Class I)	
Physical Therapy	Covered			
Occupational Therapy	Covered			
Speech, Hearing & Language Disorders	Covered			

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Prescribed Drugs	Covered (Nominal Copay)	Covered (Formulary & \$5/\$10 copay per prescription) Generic/Brand	Covered (Formulary & \$10/\$20 copay per prescription) Generic/Brand	Covered (Formulary & \$0/\$5 copay at or below 35% FPL \$5/\$10 copay above 35% FPL per prescription) Generic/Brand
Medical Supplies	Covered	Covered	Covered	Covered (Limited Coverage)
Dentures	Covered (Nominal Copay)			
Prosthetic/Orthotics	Covered			
Eyeglasses	Covered (Nominal Copay)			
Diagnostic	Covered	Covered	Covered	Covered (Copays)
Rehabilitative	Covered			
ICF for Mentally Retarded	Covered			
Inpatient Psych for Beneficiaries Under 21	Covered			
Nursing Facility for Beneficiaries Under 21	Covered			
Emergency Hospital	Covered	Covered (\$25 copay for services that do not meet the criteria of life threatening, required stabilization or result in an admission)	Covered (\$25 copay for services that do not meet the criteria of life threatening, required stabilization or result in an admission)	Covered (\$25 copay for services that do not meet the criteria of life threatening, required stabilization or result in an admission)
Personal Care	Covered			
Transportation	Covered			
Case Management	Covered			
Hospice Care	Covered			
Respiratory Care	Covered			

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Mental Health	Covered	Covered (Limited Benefit with All Services Provided through the CMHSP)	Covered (Limited Benefit with All Services Provided through the CMHSP)	Covered (Limited Benefit with All Services Provided through the CMHSP)
Substance Abuse	Covered	Covered (Limited Benefit with All Services Provided through the Coordinating Agency)	Covered (Limited Benefit with All Services Provided through the Coordinating Agency)	Covered (Limited Benefit with All Services Provided through the Coordinating Agency)